DIA FILE REQUEST

Please fill out this information as fully as possible.

TO: The Keeper of Records
Dept. of Industrial Accidents
600 Washington St., 7th Floor
Boston, MA 02111

Requesting Party: ____ Injured Worker/Employee

____ Employee's Counsel: ____ Current or ____ Former

____ Insurer's Counsel

____ 3rd Party Representative: _____
(Name of 3rd Party)

____ Other: _____
(Please Specify)

PLEASE NOTE: If you are not listed in our records as a party to the case you wish to view and/or obtain copies of documents from, we will need a signed authorization from the Employee.

Name of Requester: _____

Address of Requester: _____

_____

Telephone Number: _____

Date Requested _____

Employee Name: _____

Address: _____

_____

Soc. Sec. # (if known): _____

Date(s) of Injury: _____

DIA #(s) (if known): _____

Employer(s): _____

Workers' Comp. Insurer: _____

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Please add any additional information you may have that will help us in locating the file.

I Am Requesting:

____ Access to view the workers' compensation record(s)
(Please be advised that after viewing a file, it may not be possible to obtain file copies the same day)

____ A copy of the entire file(s)

____ A copy of the Lump Sum Settlement

____ A copy of a specific form/document, i.e., Employer's First Report of Injury , Employee's Claim, Agreement to Pay Compensation, Conference Order, Hearing Decision, etc.

_____
(Specify Form/Document)

(v.08/23/05)